29 M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

07037

CERTIFICATE OF DEATH

Reg. Diat. No. 184

1. PLACE OF DEATH:
County Harford
City or town Churchville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Churchville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Cenith A Andrews

3.(b) Social Security Number No

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Lewis Andrews
6.(c) If alive, give age: Alive years
7. Birth date of deceased (mo., day, yr.): April 30, 1861
8. AGE: Years 84 Months 2 Days 22 If less than one day ... hrs. ... min.
9. Birthplace: Alleghany Co., N.C. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: at Home
FATHER 12. Name: W. M. Beck
FATHER 13. Birthplace: Alleghany Co., N.C.
MOTHER 14. Maiden name: Rachel Henderson
MOTHER 15. Birthplace: Alleghany Co., N.C.
16. Informant: Mr. Lewis Andrews
Address: Bel-Air, Md. R. D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22 1945 (month) (day) (year)
Cemetery or crematory: Harmony Cem.
Location: Harford Co., Md.
18. Funeral director: H. S. Bailey
Address: Darlington Md.
19. July 22 1945 (Date rec'd by registrar) M. K. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 1945 at 1 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1943 to July 20 1945
and that I last saw h... alive on July 20 1945

	DURATION
Immediate cause of death: Cerebral thrombosis	12 hrs
Due to: Arteriosclerotic C.V. Disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Churchville Md. Date signed July 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07432

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:
County: Harford
City or town: Rural - Forest Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year 6 mo.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Rural - Forest Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edward Baird

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Hannah E Baird
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Nov 13 1870

8. AGE: Years	Months	Days	If less than one day
74	7	28	hrs. min.

9. Birthplace: Rocks Harford Co Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farmer

FATHER
12. Name: James Baird
13. Birthplace: Ireland

MOTHER
14. Maiden name: Elizabeth Irvin
15. Birthplace: Not Known

16. Informant: Elizabeth Baird
Address: Forest Hill Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 13-1945 (month) (day) (year)
Cemetery or crematory: North East
Location: Rocks Harford Co Md.

18. Funeral director: Martin G Kent
Address: Jarrettsville Md.

19. July 13 1945. (Date rec'd by registrar) Thomas R Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11th 1945, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10- 1944, to July 11 1945
and that I last saw him alive on May 3 1945

Immediate cause of death: CORONARY THROMBOSIS — DURATION: Sudden Death
Due to: ARTERIOSCLEROTIC HEART DISEASE — DURATION: 3 yrs.
Due to: — DURATION:
Other conditions: — DURATION:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other
Address: Forest Hill, Md Date signed: 7/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

07038

CITIES OR CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 185-

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3 Hanover St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Victoria T. Ballard

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 29 1945

8. AGE: Years | Months: 6 | Days | If less than one day: hrs. min.

9. Birthplace: Aberdeen, Harford Co. Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: Harry L. Ballard
13. Birthplace: Hoult. N. C.

MOTHER
14. Maiden name: Maggie L. Avery
15. Birthplace: Plumbtree N.C.

18. Informant: Mr. Harry L. Ballard
Address: 3 Hanover St

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 30 1945 (month) (day) (year)
Cemetery or crematory: Bristol
Location: Bristol Va.
18. Funeral director: Henry Jarrington Sons
Address: Aberdeen Md.

19. July 29 1945 (Date rec'd by registrar) G. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1945 at 1 28 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Diarrhoea	12 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gerald C Palmer M.D.
Deputy Medical Examiner
Harford County
M. D. or other
Address: Bel Air, Md. Date signed 7/28/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (98-E)

07039

CERTIFICATE OF DEATH

★ Reg. Diat. No. 182

1. PLACE OF DEATH:
County Harford
City or town Rural - Bel Air
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, institution, or street address where death occurred:
Almshouse (Harford Co.)
How long in hospital or institution? 3 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Havre De Grace Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Henry Burke

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: ?
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 4, 1867

8. AGE:

Years	Months	Days	If less than one day
78	0	9	..... hrs. ..... min.

9. Birthplace: Havre De Grace, Harford Co. Md
(Town, county, and state)
10. Usual occupation: Fisherman
11. Industry or business: —

FATHER
12. Name: James Burke
13. Birthplace: Harford Co. Md

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Henry Burke, Jr.
Address: Baltimore, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 15, 1945 (month) (day) (year)
Cemetery or crematory: Angel Hill 7/15/45
Location: Havre de Grace
18. Funeral director: Pennington & Son
Address: Havre de Grace

19. 7/13/45 (Date rec'd by registrar) Priscilla Fawcett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13, 1945, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1945, to July 13, 1945 and that I last saw h[illegible] alive on July 13, 1945

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	13 da
Due to	
Due to	
Other conditions: Chr. Myocardial Disease	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury injured at work?

23. SIGNATURE: Willard P. Hudson, M. D. or other
Address: Forest Hill, Md. Date signed 7/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

07040

Reg. Dist. No. 196

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH

County Harford

City or town Havre de Grace, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day 2 hrs.

Hospital, institution, or street address where death occurred:
Harford Memorial Hospital

How long in hospital or institution? 1 day 2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Harford

City or town Bel Air
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt #1 c/o Little Flower.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Richard Douglas Chappell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	S.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 2, 1945

8. AGE:

Years	Months	Days	If less than one day
			2 hrs. ..... min.

9. Birthplace Havre de Grace, Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Nevitt Booker Chappell

13. Birthplace Virginia

MOTHER 14. Maiden name Dorothy Ruth Brock

15. Birthplace West Virginia

16. Informant Dorothy Chappell - Mother
Address c/o Little Flower - Rt #1 Bel Air Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 4 / 45 (month) (day) (year)

Cemetery or crematory Mt Zion

Location Fountain Green

18. Funeral director Dean & Foster

Address Bel Air

19. July 3 1945 A. L. Lewis M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1945, at 9:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1945 to July 3 1945 and that I last saw him alive on July 3 1945

Immediate cause of death Congenital pulmonary atelectasis

Due to Premature labor (2 mos.)

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION
1 day

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Ralph Hurley M. D. or other

Address Elkton, Md. Date signed July 3

(M)

CITIES CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

07641

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Months 11 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 114 Wilson

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Bert Franklin Craft

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 19 - 1945

8. AGE: Years	Months	Days	If less than one day
—	2	11	..... hrs. ..... min.

9. Birthplace Havre de Grace, Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Bert A. Craft

13. Birthplace North Carolina

MOTHER 14. Maiden name Mary Evans

15. Birthplace North Carolina

16. Informant Bert A. Craft

Address 114 Wilson St., Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/31/45 (month) (day) (year)

Cemetery or crematory Angel Hill

Location Havre de Grace

18. Funeral director Pennington & Son

Address Havre de Grace

19 July 31 19 45 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 19 45 at 3A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 1945 to July 31 1945 and that I last saw him alive on July 31 1945

Immediate cause of death	DURATION
(a) Hemorrhage	1 week
Due to (b) Congenital cleft lip.	
Due to (c)	
Other conditions Mongolian Idiocy	

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address Havre de Grace Md. Date signed July 31, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

MARGIN RESERVED FOR BINDING

(1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(7)

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

07042

Reg. Dist. No. 18 5-

1. PLACE OF DEATH:

County Harford

City or town Perryman

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Harford

City or town Perryman

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Margaret Cornelia Denham

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife John Doyle Denham

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1867

8. AGE:

Years	Months	Days	If less than one day
77	8	3	— hrs. — min.

9. Birthplace Md. Harford Co.

(Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business Retired

FATHER 12. Name Robert A. Waters

13. Birthplace Md.

MOTHER 14. Maiden name Amanda Delebat

15. Birthplace Md.

16. Informant Mrs. Adele Courtney

Address Perryman, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 2 1945 (month) (day) (year)

Cemetery or crematory Spesutia Cem.

Location Harford Co. Md.

18. Funeral director R. Madison Mitchell

Address Havre de Grace Md.

19. Aug 1 1945 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1945, at 12 22 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23 1945, to July 31 1945 and that I last saw her alive on July 30 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	8 days
Due to arteriosclerosis	years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. L. Lewis M. D.

M. D. or other

Address Havre de Grace Date signed 7-31-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (191a)

07433

CERTIFICATE OF DEATH

Reg. Diat. No. 183

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Norrisville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Norrisville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Joseph H. Duncan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Rose Duncan

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 27, 1867

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
78	10	29		

9. Birthplace: Norrisville Md (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business: Farming

FATHER — 12. Name: Jno Duncan

13. Birthplace: Harford Co Md

MOTHER — 14. Maiden name: Sallie B Smith

15. Birthplace: Virginia

16. Informant: J. B. Duncan

Address: Stewartstown Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 29 1945 (month) (day) (year)

Cemetery or crematory: Norrisville

Location: Norrisville Md

18. Funeral director: W Howard Webb

Address: Fawn Grove Pa

19. July 29 1945 (Date rec'd by registrar) Thomas R Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1945 at 8:50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 1945, to July 25 1945 and that I last saw him alive on July 25, 1945

	DURATION
Immediate cause of death: Coronary Occlusion	5 hrs.
Due to: Cardiovascular Renal Disease	7 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Edward H. Hyson M. D. or other

Address: Fawn Grove Pa Date signed: July 27 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 24a

07043

CERTIFICATE OF DEATH

Reg. Diat. No. 184

1. PLACE OF DEATH:

County: Harford

City or town: Street

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Street

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Annie M Timmons

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Oscar W Timmons

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 13 1879

8. AGE: Years: 65 | Months: 8 | Days: 16 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Harford Co Md

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Housekeeping

FATHER — 12. Name: Thomas W Wright

13. Birthplace: Harford Co Md

MOTHER — 14. Maiden name: Rachel A Scarborough

15. Birthplace: Harford Co Md

18. Informant: Estella L Timmons

Address: Bel Air Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 31 1945 (month) (day) (year)

Cemetery or crematory: Shuter Ridge

Location: Delta Pa

18. Funeral director: W Howard Pyle

Address: Fawn Grove Pa

19. 8/1 1945 (Date rec'd by registrar) Carl E. Knoop Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29 1945 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1945 to July 29 1945 and that I last saw her alive on July 29 1945

Immediate cause of death: Coronary Thrombosis — DURATION: 3 mos.

Bronchopneumonia — 3 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Josiah A. Hunt, M.D. M. D. or other

Address: Cardiff, Md. Date signed: 7/31/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

07044

CERTIFICATE OF DEATH

★ Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford Co

City or town: Bel Air, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: ~~Md~~ W. Va County: ~~Harford~~

City or town: ~~Charles F Fifer~~ Charlestown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Edward J. Fifer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife: Ann D. Fifer

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): Sept 13 1894

8. AGE:

Years	Months	Days	If less than one day
50	10	13	..... hrs. ..... min.

9. Birthplace: Savannah, Georgia (Town, county, and state)

10. Usual occupation: Electrician

11. Industry or business

FATHER

12. Name: Tom Thumb Fifer

13. Birthplace: Penn

MOTHER

14. Maiden name: Lila Coughlin

15. Birthplace: Georgia

16. Informant: Mrs Annah Fifer

Address: Charlestown - W Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 29 45 (month) (day) (year)

Cemetery or crematory: Edge Hill

Location: Charlestown W. Va

16. Funeral director: Dean & Foster

Address: Bel Air Md

19. 7-26 1945 Priscilla Fawcett

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1945, at 4P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Gerald C Palmer M.D. Deputy Medical Examiner Harford County M. D. or other

Address: Bel Air, Md. Date signed 7/26/45

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

VS-002

WEST VIRGINIA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Dist. No. ..... Serial No. .....

P. D. | Res. | Vet. | S.S. No. | Sex | Col. | C. C. | Occ. | B. P. | Cause | Con't. | C. E. | Acc.

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct especially important. Physicians: please write the causes of death clearly and legibly.

1. Place of Death:
(a) County .....
(b) Magisterial District .....
(c) City or town ..... (If outside city or town limits, write RURAL and give town)
(d) Address ..... (Street address, hospital, or institution)
(e) Length of stay in hospital or inst. (yrs., mos., or days) .....
(f) Length of stay in this community (yrs., mos., or days) .....

2. Home (Usual Residence) of Deceased:
(a) State ..... (b) County .....
(c) City or town ..... (If outside city or town limits, write RURAL and give town)
(d) Street No. ..... (If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years. ✓

3 (a) Full Name Edward Farrell Fifer

3 (b) If veteran, name war

3 (c) Social Security No. 456-05-3349

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Anna Duncan Fifer

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Sept. 13 - 1894

8. Age: Years 50 | Months 10 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Savannah Georgia (Town, county, and state)

10. Usual occupation .....

11. Industry or business Electrician

Father
12. Name Wm Henry Fifer
13. Birthplace Penna

Mother
14. Maiden Name Lilla Wright
15. Birthplace Georgia

16 (a) Informant's signature Mrs. Anna D. Fifer
(b) Address Charlestown.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29 - 45 (month) (day) (year)
(c) Cemetery or crematory Edge Hill
Location Charlestown. W Va

18 (a) Funeral director (signature) Lynn T. Stuck
(b) Address Charlestown.
Fr. Dir. License No. 27 Embalmers No. 285

19. Filed ..... 19..... Registrar.

MEDICAL CERTIFICATION

20. Date of death ..... 19....., at ..... M.

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19....., to ..... 19....., and that I last saw him alive on ..... 19.....

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If external causes contributed to the death fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature ..... M. D. or other
Address ..... Date signed

07434

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-e

CERTIFICATE OF DEATH

★ Reg. Dist. No. 183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Cooptown Md. (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 7 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Rural - Jarrettsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Cooptown
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Blanche Holmes Ford

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	widow

6.(b) Name of husband or wife: Wm Floyd Ford
(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 22, 1870

8. AGE: Years	Months	Days	If less than one day
74	11	4	..... hrs. ..... min.

9. Birthplace: Darien McIntosh Ga.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Jenkins M. Holmes
13. Birthplace: Charleston, S.C.

MOTHER
14. Maiden name: Laura Wright
15. Birthplace: Crawford Co. Ga.

16. Informant: Mrs. Ida M. Morse
Address: Forest Hill Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 28, 1945 (month) (day) (year)
Cemetery or crematory: Wm Watters Memorial
Location: Cooptown, Md.

18. Funeral director: Martin D. Kurtz
Address: Jarrettsville Md

19. July 28, 1945 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26, 1945, at 5.50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 45, to July 26 19 45
and that I last saw her alive on July 25 19 45

Immediate cause of death: CARCINOMA OF COLON — DURATION: 5

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other
Address: Forest Hill Md. Date signed: 7/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-E)

CERTIFICATE OF DEATH

07045

★ Reg. Diat. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Forest Hill, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 61 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Forest Hill, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Carrie Virginia Forwood.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: John B Forwood

6.(c) If alive, give age ← years

7. Birth date of deceased (mo., day, yr.): May 11 - 1866

8. AGE:

Years	Months	Days	If less than one day
79			..... hrs. ..... min.

9. Birthplace: Harford Co Md (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER

12. Name: John Martin

13. Birthplace: Md.

MOTHER

14. Maiden name: Margaret - Unknown

15. Birthplace: Md

16. Informant: Miss Bessie Forwood.

Address: Forest Hill

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 29 1945 (month) (day) (year)

Cemetery or crematory: Centre Methodist

Location: Forest Hill, Md

18. Funeral director: Dean & Foster

Address: Bel Air Md.

19. 7/29 1945 Priscilla Forwood

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27, 1945, at 4 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 1945 to July 27 1945

and that I last saw h...f alive on July 27 1945

Immediate cause of death	DURATION
Coronary Thrombosis	2 da.
Due to	
Due to	
Other conditions: Ch. Myocardial Disease > Prolapse uteri & Urinary bladder Retention	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other

Address: Forest Hill Md Date signed 7/29/45

3 PM.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

07046

Reg. Dist. No. 182

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Harford

City or town: Bel Air (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? UNKNOWN

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Bel Air, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Grier

3.(b) Social Security Number: 374-16-3381

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	UNKNOWN

6.(b) Name of husband or wife: UNKNOWN

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 15 1900

8. AGE:

Years	Months	Days	If less than one day
44			..... hrs. ..... min.

9. Birthplace: N.C.
(Town, county, and state)

10. Usual occupation: Race Track.

11. Industry or business

FATHER
12. Name: Wm Grier
13. Birthplace: N.C

MOTHER
14. Maiden name: Alice Henton
15. Birthplace: N.C.

16. Informant: Police Record (State)

Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 9 1945 (month) (day) (year)

Cemetery or crematory: Harford Co Home

Location: Near - Bel Air, Md

18. Funeral director: Dean & Foster

Address: Bel Air, Md

19. 7-8 1945 Priscilla Fawcett
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 1945 at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Fracture skull	Instant
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 7/5/45

Where did injury occur? Fallston (City or town) Harford (County) Md (State)

Injured at home, farm, industry, public place (where?) U.S. Route 1

Means of injury Hit by car Injured at work? no

23. SIGNATURE: Gerald C Palmer M.D.
Deputy Medical Examiner
Harford County
M. D. or other

Address: Bel Air, Md Date signed 7/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46 (P)

07047

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:
County Harford
City or town Edgewood R.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 40 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Edgewood R.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Annie E. Gross.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Amos L. Gross
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 13 1866

8. AGE: Years	Months	Days	If less than one day
78	9		..... hrs. ..... min.

9. Birthplace Penna (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Baer
13. Birthplace unknown
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown
16. Informant Mrs Emmond Hawsons
Address Edgewood Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 15 1945 (month) (day) (year)
Cemetery or crematory Mt. Carmel
Location Emmorton Maryland
18. Funeral director Howard K McComas Son
Address Aberdeen Maryland
19. July 14 1945 (Date rec'd by registrar) Marie M. Mansdale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1945 at 4:10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 26 1945 to July 13 1945 and that I last saw her alive on July 12 1945

Immediate cause of death	Carcinoma of Liver	DURATION 3 MOS.
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

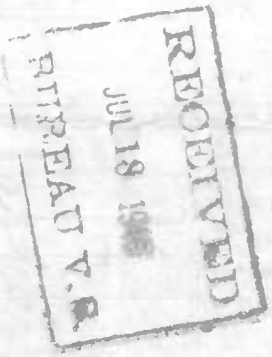
23. SIGNATURE Clifford F. Hudson M.D.
M. D. or other
Address Fork Md Date signed 7/14/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

McComas



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

67048

Reg. Dist. No. 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Edgewood, R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Mos
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: W. Va. County: Logan
City or town: Logan
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Albie Elba Blair Hall (Hall)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 28, 1932

8. AGE: Years	Months	Days	If less than one day
13	1	29	hrs. min.

8. Birthplace: Omar W. Va.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Walter Hall
13. Birthplace: Kentucky

MOTHER
14. Maiden name: Mendy Moore
15. Birthplace: Kentucky

16. Informant: Mendy Blair
Address: Edgewood Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: July 30, 1945
(month) (day) (year)
Cemetery or crematory: Abingdon Methodist, (Cokesbury)
Location: Abingdon Md.

18. Funeral director: Howard K. McComas & Son
Address: Abingdon Md.

19. July 30 '45 (Date rec'd by registrar) Mina M. Mockabee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 19 45 at 11 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Accidental drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 7/27/45
Where did injury occur? Edgewood (City or town) Harford (County) Md. (State)
Injured at home, farm, industry, public place (where?) Winters Run
Means of injury: Drowned Injured at work? no
Beulet C. Palmer MD
Deputy Medical Examiner
Harford County

23. SIGNATURE: M. D. or other
Address: Bel Air Md. Date signed: 7/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

07049

Reg. Dist. No. 182

1. PLACE OF DEATH:
County Harford
City or town Forest Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED.
(For newborn infants give residence of mother)
State Md. County Harford
City or town Forest Hill Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Alma E. Rost Hudson

3. (b) Social Security Number

4. Sex F

5. Color or race W.

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Wm S. Hudson

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 5 - 1876

8. AGE: Years 68 Months 11 Days 23 If less than one day hrs. min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name Rudolph Rost

FATHER 13. Birthplace Germany

MOTHER 14. Maiden name Wilmont

MOTHER 15. Birthplace Unknown

16. Informant Dr. C. L. Hudson

Address Fork Md.

17. Burial (Burial, cremation, or removal — which?) Date thereof July 16 1945 (month) (day) (year)

Cemetery or crematory M. Zion

Location Fountain Green Md.

18. Funeral director Deaver & Sated

Address Bel Air Md

19. 7/13/45 Priscilla Lowood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1945, at 8:55 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 25 1945 to July 13 1945 and that I last saw her alive on July 13 1945

Immediate cause of death	DURATION
Cerebral Embolism	3 Days
Due to Diabetic Gangrene of L. Foot	18 Da.
Due to Diabetes Mellitus	17 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clifford F. Hudson, M.D.
M. D. or other
Address Fork, Md. Date signed 7/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

107050

Reg. Dist. No. 185

1. PLACE OF DEATH:

County: Harford County.

City or town: Havre de Grace Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days.

Hospital, institution, or street address where death occurred: Harford Memorial Hospital.

How long in hospital or institution? 11 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural - Aberdeen.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Emily Elizabeth Huff.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B.(b) Name of husband or wife: William Henry Huff.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 11th 1868

8. AGE: Years	Months	Days	If less than one day
77	4	4	..... hrs. ..... min.

9. Birthplace: Scarsdale, Maryland (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER — 12. Name: Joshua Courtney Huff.

13. Birthplace: Street, Maryland

MOTHER — 14. Maiden name: Martha Delelma Huff.

15. Birthplace: Aberdeen Md.

16. Informant: Mrs. John Garish

Address: Aberdeen Md. R.F.D. #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17 - 1945 (month) (day) (year)

Cemetery or crematory: Emory, Harford County Md.

Location: Near Street Maryland

18. Funeral director: Ekura Jarrin Sons

Address: Aberdeen Md.

19. July 16 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 1945, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 17 1944, to July 15 1945

and that I last saw her alive on July 15 1945

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Chronic Myocarditis	
Due to: Chronic Nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: A. L. Lewis M.D. M. D. or other

Address: Havre de Grace Md. Date signed 7-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-2)

07051

CERTIFICATE OF DEATH ★

Reg. Dist. No. 180

1. PLACE OF DEATH:
County: Harford
City or town: Edgewood Arsenal
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, institution, or street address where death occurred:
Station Hospital
How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: —
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1501 Pentridge Road
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II ✓

3.(a) FULL NAME: INGLE, William W.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Janet Ingle
6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): 16 November, 1906

8. AGE: Years	Months	Days	If less than one day
38	7	15	..... hrs. ..... min.

9. Birthplace: Burlington, Alamance, North Carolina
(Town, county, and state)
10. Usual occupation: Army officer
11. Industry or business: U. S. Army

FATHER
12. Name: John V. Ingle
13. Birthplace: Burlington, Alamance, North Carolina

MOTHER
14. Maiden name: Lottie Isley
15. Birthplace: Burlington, Alamance, North Carolina

16. Informant: Brother, John Ingle
Address: 2700 Kilgore Avenue, Raleigh, No. Car.

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: July 2 1945 (month) (day) (year)
Cemetery or crematory: Rich + Thompson Funeral Service
Location: Burlington North Carolina
18. Funeral director: Howard C. McCormas Son
Address: Abingdon Maryland

19. July 2 1945 (Date rec'd by registrar) Marie M Mouldedale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 July 1945 at 410 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 June 1945, to 1 July 1945 and that I last saw him alive on 11:30 PM 30 June 1945

Immediate cause of death	DURATION
Peritonitis, general	5 Days
Due to: Perforated Duodenal ulcer	11 hrs.
Due to:	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operation: Perforated Duodenal ulcer
Date of op. 23 June 45
Autopsy results: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Frank N. Volk
FRANK N. VOLK, CAPT., MC M. D. or other
Address: Edgewood Arsenal, Md. Date signed: July 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

07052

★ Reg. Dist. No. 185-

1. PLACE OF DEATH

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day 17 hrs -

Hospital, institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 1 day 17 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md Pa County: Delaware

City or town: Chester

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Leonard Jackson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Colored	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
About 65	x	x		

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: No Record

13. Birthplace: " "

MOTHER 14. Maiden name: No Record

15. Birthplace: " "

16. Informant: Harford Memorial Hospital

Address: Havre de Grace

17. Burial (Burial, cremation, or removal Which?) Date thereof July 18, 1945 (month) (day) (year)

Cemetery or crematory: St. James Cemetery

Location: Havre de Grace Md

18. Funeral director: Elmer E. Bullock

Address: 556 Lewis St. Havre de Grace

19. July 18 1945 (Date rec'd by registrar) E. K. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 1945, at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 1945, to July 17 1945

and that I last saw him alive on July 17 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to: Cardio-renal Hypertensive Disease	2
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Ruffin Hurley M.D. M. D. or other

Address: Lanesville Md. Date signed July 19

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07053

Reg. Diat. No. 182

1. PLACE OF DEATH:

County: Harford Co

City or town: Upper x Roads

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Upper x Roads Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Sarah C. Lane

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: Robert Lane

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 19 - 1861

8. AGE: Years 83 | Months 6 | Days 11 | If less than one day: hrs. min.

9. Birthplace: Virginia (town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John Hockett

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Robert Lane

Address: Baldwin Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 4-45 (month) (day) (year)

Cemetery or crematory: Fork M. E. Cem

Location: Fork Md.

18. Funeral director: Clarence E. Arthur

Address: Fork Md.

19. 7/3/45 (Date rec'd by registrar) Priscilla Forwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 1945, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 3 1942 to July 1, 1945 and that I last saw her alive on June 30, 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 hr
Due to: Hypertensive Cardio-Vascular Disease	5 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clifford F. Hudson, M.D.

M. D. or other

Address: Fork, Md. Date signed: 7/2/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

07054

CERTIFICATE OF DEATH

Reg. Diat. No. 185

1. PLACE OF DEATH

County: Harford

City or town: Havre de Grace, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Florida County: —

City or town: Miami
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3245 S.W. - 1st Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME Major Edward Laughlin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Elizabeth Laughlin

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): October 21, 1880

8. AGE: Years	Months	Days	If less than one day
64	8	19	...hrs. ...min.

9. Birthplace: Indiana (Town, county, and state)

10. Usual occupation: Retired Army Major

11. Industry or business: —

FATHER
12. Name: John Laughlin
13. Birthplace: Indiana

MOTHER
14. Maiden name: Rachael Whitesford
15. Birthplace: Indiana

16. Informant: Mrs. Elizabeth Laughlin
Address: 3245 S.W. 1st Ave, Miami Fla.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/13/45 (month) (day) (year)

Cemetery or crematory: Arlington Md.

Location: Arlington Va.

18. Funeral director: Pennington & Son

Address: Havre de Grace, Md.

19. 7-12 1945 A. C. Lewis M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 1945, at 2A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h...alive on ...19...

Immediate cause of death	DURATION
Coronary occlusion	—
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: Gerald C Palmer M.D.
Deputy Medical Examiner
Harford County M. D. or other

Address: Bel Air, Md. Date signed 7/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

07055

Reg. Dist. No. 184

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Dublin Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Rural - Bel Air.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Bel Air
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Maggie M. Lyall

3.(b) Social Security Number:

4. Sex: Female | 5. Color or race: White | 6.(a) Single, married, widowed, ~~or divorced~~: Widow

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 29, 1874

8. AGE: Years: 71 | Months: 1 | Days: 12 | If less than one day: hrs. min.

8. Birthplace: Ash Co., N. C.
(Town, county, and state)

10. Usual occupation: Housework at Home

11. Industry or business:

FATHER
12. Name: James Dixon
13. Birthplace: Ash Co., N. C.

MOTHER
14. Maiden name: Casby Center
15. Birthplace: Ash Co., N. C.

16. Informant: James H. Barton
Address: Street, Md. R. D.

17. Removal (Burial, cremation, or removal, which?) Date thereof: July 12 1945 (month) (day) (year)
Cemetery or crematory: West Jefferson
Location: Ash Co., North Carolina

18. Funeral director: H. L. Bailey
Address: Darlington, Md.

19. July 11, 1945 (Date rec'd by registrar) M. A. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11th 1945, at 8:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1945, to July 11 1945
and that I last saw her alive on July 10 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	3da
Due to:	
Due to:	
Other conditions: Essential Hypertension	
Ch. Bronchial Asthma	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other
Address: Forest Hill, Md. Date signed: 7/12/45

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07056

Reg. Dist. No. 85-

1. PLACE OF DEATH:

County Harford.

City or town Havre de grace

(If outside city on town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Harford Memorial Hosp.

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford Cecil.

City or town Port Deposit Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Frank Maclain

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro.	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 4, 1886

8. AGE: Years 59 | Months 9. | Days | If less than one day ... hrs. ... min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual occupation Fireman

11. Industry or business

FATHER 12. Name Lee Mac Lain

FATHER 13. Birthplace North Carolina

MOTHER 14. Maiden name Martha Arnold

MOTHER 15. Birthplace North Carolina

16. Informant Harford Memroial Hospital Record

Address Havre De Grace, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 5, 1945 (month) (day) (year)

Cemetery or crematory

Location To Fuquay Springs, N. Carolina

18. Funeral director Lee A. Patterson & Son

Address Perryville, Md.

19. July 5 1945 (Date rec'd by registrar) C. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1945, at 8 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 27 1945, to July 4 1945

and that I last saw h alive on July 4 1945

Immediate cause of death	DURATION
Coronary thrombosis	1 Day
Due to Carcinoma of prostate	1 yr.
Due to C. Metastasis	?
Other conditions Scarlet Oedema	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Colbert M.D. M. D. or other

Address Havre de Grace Date signed July 4 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

07057

CERTIFICATE OF DEATH

Reg. Dist. No. 182

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Rural — Bel Air
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Rural - Bel Air
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Martha J. McMillian

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: William McMillian
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 29 - 1872

8. AGE: Years: 73 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: Wm H Reed
13. Birthplace: N.C

MOTHER — 14. Maiden name: Matilda Richardson
15. Birthplace: N.C.

16. Informant: Rev F E Thompson
Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 4 - 1945 (month) (day) (year)
Cemetery or crematory: Nathan's Creek
Location: Nathan's Creek N.C.

18. Funeral director: Dean & Tate
Address: Bel Air Md

19. 7/2 (Date rec'd by registrar) 19 45 Priscilla Fourwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 19 45, at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 - 19 45 to July 1 - 19 45
and that I last saw h on alive on June 30 19 45.

	DURATION
Immediate cause of death: CARCINOMA COLON	2 yrs??
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Weland P. Hudson M. D. or other
Address: Forest Hill Md Date signed: 7/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

07058

CERTIFICATE OF DEATH

★ Reg. Diat. No. 184

1. PLACE OF DEATH:
County: Harford
City or town: Darlington Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 513 N. Potomac Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Stanley Percival Miller Miller

3.(b) Social Security Number: 213-07-7913

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Marian D. Miller
6.(c) If alive, give age: 45 years
7. Birth date of deceased (mo., day, yr.): August 23, 1899

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
45	10	15		

9. Birthplace: Washington County, Penna. (Town, county, and state)
10. Usual occupation: Foreman
11. Industry or business: Sawmill
FATHER 12. Name: Franklin Miller
FATHER 13. Birthplace: Washington County, Penna
MOTHER 14. Maiden name: Dora Howard
MOTHER 15. Birthplace: Unknown
16. Informant: Marian D. Miller
Address: 513 N. Potomac Street.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-19-45 (month) (day) (year)
Cemetery or crematory: Parkwood Cemetery
Location: Taylor Avenue
19. Funeral director: Frederick D. Miller, Inc
Address: 3019 E. Monument Street
19. July 16 1945 M. D. Kirk
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 1945 at 7P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19— to — 19—
and that I last saw h— alive on — 19—

Immediate cause of death	DURATION
Coronary occlusion	—
Due to	
Due to	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gerald C Palmer M D
Deputy Medical Examiner Harford County M. D. or other
Address: Bel Air, Md. Date signed 7/15/45

VS A15 (1) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (946)

CERTIFICATE OF DEATH

07059

★ Reg. Dist. No. 182

1. PLACE OF DEATH:
County Harford Co.
City or town Fallston
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State [redacted] County Medina
City or town Medina Ohio
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Earlam E. Pearse

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of ~~husband~~ or wife Mary K Pearse
6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) April 17th 1874

8. AGE: Years	Months	Days	If less than one day
71	3	8	....hrs. ....min.

9. Birthplace Mansfield Ohio
(Town, county, and state)
10. Usual occupation Retired Railroad Man
11. Industry or business

FATHER
12. Name Edward Pearse
13. Birthplace England.

MOTHER
14. Maiden name Unknown.
15. Birthplace England.

16. Informant Mrs W. Meyerhein
Address Fallston

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30 1945 (month) (day) (year)
Cemetery or crematory Medina Ohio
Location Medina Ohio

18. Funeral director J. E. Tyson
Address Rising Sun Md

19. 7-25 1945 Priscilla Fourroux
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1945 at 830 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1945 to July 25 1945 and that I last saw h[redacted] alive on July 24 1945

Immediate cause of death	DURATION
Cerebral Embolism	7 days
Due to Arterial Sclerosis	many years
Due to	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations none
— Date of op. —
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide none Date of —
Where did injury occur? none (City or town) — (County) — (State)
Injured at home, farm, Industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE W. Millard Stirling M.D.
M. D. or other
Address Fallston Md Date signed 7/25/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

67060

FILM No. G 97 JUL 25 1945

★ Reg. Dist. No. 185

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Bethel Memorial Hospital

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural Aberdeen

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Lewis Albert Pitt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Ella Whines

6.(c) If alive, give age: Colored years

7. Birth date of deceased (mo., day, yr.): Feb 2 - 1882 — 65

8. AGE: Years	Months	Days	If less than one day
63 ~~62~~	5		...hrs. ...min.

9. Birthplace: Perryman Md. (Town, county, and state)

10. Usual occupation: Day Laborer

11. Industry or business: On Farm

FATHER — 12. Name: Albert James Pitt

FATHER — 13. Birthplace: Perryman Md.

MOTHER — 14. Maiden name: Mary L. Stansbury

MOTHER — 15. Birthplace: Perryman Md.

16. Informant: Mrs. John L. Pitt

Address: Aberdeen Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 21-1945 (month) (day) (year)

Cemetery or crematory: Union M. E.

Location: Near Aberdeen Md.

18. Funeral director: Bevans Lasting Home

Address: Aberdeen Md.

19. July 20 1945 (Date rec'd by registrar) — C. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-19-45 19... at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 6-24 19 45, to 7-19 19 45

and that I last saw him alive on 7-18-45 19...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: following Hemiplegia	
Due to: done one week earlier	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. L. Lewis M.D. M. D. or other

Address: Havre de Grace Md. Date signed: 7-20-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

07061

Reg. Diat. No. 184

1. PLACE OF DEATH:

County Harford

City or town Darlington (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Harford

City or town Darlington (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Octavia C. Pyle

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife William C. Pyle

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 6, 1870

8. AGE:	Years	Months	Days	If less than one day
	75	1	13	..... hrs. ..... min.

9. Birthplace Harford Co. Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Milton J. Bennington

13. Birthplace Harford Co. Md.

MOTHER 14. Maiden name Elizabeth Daugherty

15. Birthplace Harford Co. Md.

16. Informant Mrs. David Hughes

Address Darlington, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 22, 1945 (month) (day) (year)

Cemetery or crematory Slate Ridge cemetery

Location Delta Pa.

18. Funeral director Hubert P. Harkins

Address Delta, Pa.

19. July 22 1945 M. V. Kirk

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1945, at 4 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 6 1945, to July 18 1945

and that I last saw h.. alive on July 18 1945

Immediate cause of death	DURATION
Coronary Thrombosis	12 Days
Due to Natural	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE E. E. Simpson M. D. or other

Address Darlington Md. Date signed 7/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

07062

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93rd

CERTIFICATE OF DEATH

★ Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 353 Giles St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harry Lee Smithson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertha L. Smithson
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): March 29, 1874.

8. AGE: Years	Months	Days	If less than one day
71	3	21	____ hrs. ____ min.

9. Birthplace: Bel Air, Harford Co., Md. (Town, county, and state)
10. Usual occupation: Merchant, Wholesale
11. Industry or business: Meat Products
12. FATHER — Name: Nathaniel Smithson
13. FATHER — Birthplace: Harford Co. Md.
14. MOTHER — Maiden name: Elizabeth Miller
15. MOTHER — Birthplace: Md.
16. Informant: Bertha L. Smithson
Address: 353 Giles St. Havre de Grace, Md.
17. Burial (Burial, cremation, or removal, Which?) Date thereof July 23, 1945 (month) (day) (year)
Cemetery or crematory: West Washington
Location: Edgara, Md.
18. Funeral director: Lee A. Patterson & Son
Address: Perryville, Md.
19. 7-22-45 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 - 1945, at 4:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13 1945 to July 20 1945
and that I last saw h[im] alive on July 20 - 1945

	DURATION
Immediate cause of death: Coronary Occlusion	
Due to: Arteriosclerosis	
Due to: Chronic Myocarditis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) ____
Means of injury: ____ Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: [illegible] Date signed 7-20-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-m)

07663

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Bel Air, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Rural - Darlington Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Infant STEELMAN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	Infant

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 10- 1945

8. AGE: Years | Months | Days | If less than one day: 2 hrs. ..... min.

9. Birthplace: Bel Air, Harford Co, Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Eugene F. Steelman
13. Birthplace: Yadkin Co, N.C.

MOTHER
14. Maiden name: Oda Rose Edwards
15. Birthplace: Grayson Co, Va

16. Informant: Mrs Oda Steelman
Address: Darlington, Md

17. (Burial, cremation, or removal, Which?) Date thereof 7/10/45 (month) (day) (year)
Cemetery or crematory: Retained for
Location: Anatomical Purposes

18. Funeral director
Address

19. 7/12 1945 Priscilla Fawwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 1945, at 10:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1945, to July 10 1945
and that I last saw h[illegible] alive on July 10 1945

Immediate cause of death	DURATION
Fetal Monstrosity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Willard P. Hudson
M. D. or other
Address: Forest Hill, Md Date signed 7/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

07064

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rt #1
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Clyde Jonathan Wallen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Single

B.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 8, 1945.

8. AGE: Years | Months | Days: 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Havre de Grace, Harford Co. Md.
(Town, county, and state)

10. Usual occupation: Infant.

11. Industry or business

FATHER
12. Name: Ora J. Wallen
13. Birthplace: Big Stone Gap Virginia

MOTHER
14. Maiden name: Maxine Roark
15. Birthplace: Ashland, N. C.

16. Informant: Maxine Wallen - Mother
Address: Rt #1 - Havre de Grace, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/26/45 (month) (day) (year)
Cemetery or crematory: Angel Hill
Location: Havre de Grace

18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.

19. July 26 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24 1945 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1945 to July 24 1945
and that I last saw h.e.r. alive on July 24, 1945

Immediate cause of death	DURATION
Premature Birth	6 mos
Due to: Terminal Pneumonia	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Charles J. Foley M.D. M. D. or other
Address: Havre de Grace Date Signed 7/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (176-C)

CERTIFICATE OF DEATH

★ 17065 184

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Harford

City or town Darlington Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Harford

City or town Edgewood Arsenal Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME (Zschauer) Walter Zschauer Serial No. 4WG22195

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife .....

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 2/1/22

8. AGE: Years	Months	Days	If less than one day
23	5	13	..... hrs. ..... min.

9. Birthplace Muenster Germany (Town, county, and state)

10. Usual occupation German Soldier

11. Industry or business

FATHER

12. Name Rudolf Zschauer

13. Birthplace unknown

MOTHER

14. Maiden name unknown

15. Birthplace unknown

16. Informant U.S. Govt records

Address Edgewood Arsenal, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17 1945 (month) (day) (year)

Cemetery or crematory P.O.W. Cemetery

Location Camp Meade Maryland

18. Funeral director Howard E. McComas Funeral

Address Aberdeen Maryland

19 July 17 19 45 M. A. Kirk

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 19 45, at 6:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Fracture skull	Instant
Due to	.....
Due to	.....
Other conditions	.....

(Include pregnancy within 3 months of death)

Major findings of operations .....

..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7/14/45

Where did injury occur? Darlington Harford Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) U.S. Route 1

Means of injury Hit by auto Injured at work? Yes

23. SIGNATURE Herbert C. Palmer M.D. Deputy Medical Examiner

Harford County

M. D. or other

Address Bel Air Md. Date signed 7/14/45